



108 Chelsea Grove Ct • Pasadena, MD 21122 Phone 410-255-0800 FAX 410-255-3522
 Satellite Offices: Salisbury and Berlin
 EMAIL - requests@fittingsbymichele.com

To allow us to dispense medical supplies and submit a claim for insurance coverage consideration,
Please complete all the items checked below & return by FAX 410-255-3522

Supply valid diagnosis & ICD-10 code(s) pertaining to medical need of supplies

Sign & Date the order (signature stamps prohibited by CMS)

Attach a recent progress note supporting medical need &/or continued use for requested supplies

Patient Name: _____ **DOB:** _____

► **Diagnosis & ICD- 10 Code(s):** _____

Upper Extremity Gradient Compression Garments

Left Right Bilateral 20-30mmHg 30-40mmHg 40-50mmHg Custom Ready Made

- Glove w/thumb stub, no fingers (AC) _____ RM: S8428/A6549 CUSTOM: S8426/S8425/A6549
- Glove with Fingers (ACFS) _____ RM: S8427/A6549 CUSTOM: S8426/S8425/A6549
- Arm Sleeve _____ RM:L8010/S8421 CUSTOM: S8423/S8422/A6549/S8421
- Compression Vest /Camisole _____
- Gradient Compression Lymphedema Pad _____
- Nighttime Grad Compression Garments: _____
- Customizable Gradient Compression Garments for Treatment Phase: _____
- Inelastic Gradient Compression Garments for Maintenance Phase: _____
- Gradient Compression Garments for Head/Neck/Chin: _____

Additional Notes: _____

QUANTITY & FREQUENCY: _____

Referring Provider: _____ **NPI:** _____

Address: _____

Phone: _____ **Fax:** _____

► _____
Referring Provider's Signature

► _____
Date

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FORM 102 DWO CG

Your patient has an appt with us on _____ **Date Requested** _____